DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	A. BUILDING 00		COMPLETED	
		152016	B. WIN	G		06/27/2	2011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
OFLECT	CDECIAL TV LICED	ITAL FORT WAYNE		1	ROADWAY 7TH FLE		
	SPECIALTY HOSP	ITAL-FORT WAYNE		FORT	WAYNE, IN46802		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
S0000	REGULATORT OR	LSC IDENTIFTING INFORMATION)	+	IAU			DATE
30000							
	The visit was for	investigation of two (2)	$ S_0$	000			1
	State hospital con						
	State nespital co.	p					
	Complaint Numb	per:					
	IN 00084347						
		eficiencies cited related					
	to the allegations						
	to the unegaviens	•					
	Complaint Numb	ner					
	IN 00089012						
		Deficiencies cited related					
	to the allegations	5.					
	Facility Number:	: 009856					
	Dates of Survey:	06/23/11 and 06/27/11					
	Dates of Survey.	00/23/11 and 00/27/11					
	Surveyor:						
	Brian Montgome	ery, RN, BSN					
	Public Health Nu	ırse Surveyor					
	QA: claughlin 0	0/15/11					
	QA. Claughilli 0	9/13/11					
			ı		l		l l

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J57R11

Facility ID:

009856

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 06/27/2	ETED
NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 BROADWAY 7TH FL E FORT WAYNE, IN46802				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
S0712	be maintained with service rendered f who is evaluated of follows: (1) Medical record accurately and in a readily accessible, retrieval of informa Based on docume record review an staff failed to do vital signs and 9 as required per policy (#26) following a document that two were provided barequired per policy. 1. The policy/preprogram (revised following under Patient will be on with vital signs: 6 hours X 4, every 24 hour period). 2. On 4-01-11 and documentation la every one hour vital signs of the provided bare the policy of the program (revised following under patient will be on with vital signs: 6 hours X 4, every 24 hour period).	nedical record shall in documentation of or each individual or treated as a sare documented a timely manner, are and permit prompt ation. The treview, medical individual dinterview, the facility cument 7 of 11 sets of of 11 neurologic checks to olicy for one patient in fall event and failed to to patients (#21, #26) aths and oral care as	So	712	Response to tag S721 1.Corrective action for the patients affected by the defice practice. • 1 current patient if fall, the assigned nursing personnel were re-educatated the post fall neuro checks an vital signs requirement. • For pt, neuro checks and vital signs requirement the medical record per policy Current patient medical record have been reviewed for documentation of patient care (i.e. baths, oral care.) Staff if been re-educated to the documentation requirements when care is provided. 2.How other patients with the potent be affected by the deficient practice will be identified and corrective action taken. • The Director of Quality Managem (DQM) and/or Chief Nursing Officer (CNO) have re-educanursing personnel to the posineuro check and vital signs requirements per policy and and oral care documentation requirements. • The DQM are	nad a d to d d or this gns ed in rds e nave v tial to e ent ted t fall	10/31/2011

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
	152016		B. WIN	IG		06/27/2	011
NAME OF	PROVIDER OR SUPPLIER	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
The state of the s			1	OADWAY 7TH FL E			
SELECT	SPECIALTY HOSP	PITAL-FORT WAYNE		FORT V	VAYNE, IN46802		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΤE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	of 4 required every two			designee will monitor complia		
	hour vital signs a	and neuro-vascular			with documentation of post for neuro checks and falls to ens		
	checks, lacked 1	of 3 required every four			compliance. • The DQM and		
	hour vital signs,	and lacked 2 of 3			designee will monitor compli		
	required every for	our hour neuro-vascular			with documentation of ADLs	and	
	checks for patier	nt #26.			oral care compliance per pol		
					3. Measures put into place o	<u>r_</u>	
	3 During an int	erview on 6-30-11 at			system changes initiated to ensure deficient practice doe	s not	
					recur. • Frequent vital/Neu		
	0710 hours, staff #S8 confirmed that only 4 of 11 sets of vital signs and 2 of 11 sets				forms will be Utilized with e		
					fall to monitor Neuro status to	0	
	of neuro-vascular checks were				include Neuro checks every		
	documented during the 24 hour post fall				x 4, every 2 hours x 4 and ev	-	
	period for patien	it #26.			hours x 3 per the policy. • S	Staff	
					will be re-educated to policy F02-G, Fall Reductions and	the	
	4. The policy/pr	ocedure Guidelines and			Frequent Vital/Neuro forms.		
	Protocols (revise	ed 10/08) indicated the			CNA staff have been re-educ		
	following under	the category Hygiene;			to the proper documentation		
	patient bathed da	aily, bed linen changed			ADL care on 24 hour flow sh		
	daily and prn, or	al care every AM before			4. How the corrective action be monitored to ensure defice		
	breakfast and ev	ery HS (hour of sleep),			practice will not recur. Who		
	1	ery 4 hours for NPO, tube			be responsible? • DQM and		
	feedings, and ve	- -			designee will audit 100% of	all	
	5. The 24 hour Patient Record for patient #21 lacked documentation that a bath was				falls that occur for Complian		
					with Fall Reduction Policy.		
					DQM and/or designee will au 30 random records per mont		
					compliance with documentat		
	1 *	30-10 and 1-02-11 or that			of ADLs and oral care for 3		
	oral care was provided on 12-30-10,				months and randomly therea	ıfter	
		02-11 between 0700 and			to maintain compliance. Auc		
	1900 hours.				results will be reviewed in the	е	
					monthly QAPI committee	orly	
	6. The 24 hour l	Patient Record for patient			meetings and reported quart to OIC/MEC/GB for additionation		
	#26 lacked docu	mentation that a bath was			improvement actions as need		
	provided on 4-01	1-11 or 4-03-11 or that			5. Responsible: DQM and		
	1 ^	ovided between 04-01-11			Date of Compliance: 10/31/	11	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
152016		152016	B. WING		06/27/2011		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	at 1600 hours unhours or 04-03-1	til 04-02-11 at 2300 1until 04-04-11.					
S0948	410 IAC 15-1.5-7 (c) Drugs and bioloprepared for adminadministered as for (5) In accordance	ogicals shall be nistration and illows:					
	acceptable standa Based on document facility failed to ensiadministered and do patients. Findings: 1. The policy/proce Administration (revi following; All sche must have correspon	rds of practice. review and interview, the ure medications were cumented per policy for 2 of 7	S0948	Response to tag S948 1.Corrective action for the patients affected by to deficient practice. No patients were negatively affected by this practice. 2.How other patients with the potential to be affected by the deficient practice will be ider and corrective action taken. Current patients MAR	<u>e</u> <u>etified</u>		
	slash (/) through the administrator's initia 2. Review of the M 12-28-10 for patient (Arixtra, Aspirin, Bi Sulfate, Fibercon, Frand Symbicort) ordegiven with a slash (/ 3. Review of the M #26 lacked pages 5 a medications. Staff	time followed by the tils. AR dated 12-27-10 and #21 indicated 10 medications accodyl, Famotidine, Ferrous accosemide, Klor-Con, Spiriva, ered and not designated as through the time. AR dated 4-01-11 for patient		have been reviewed for prop Medication Administration documentation. 3. Measures put into place of system changes initiated to ensure deficient practice does recur. Registered Nurse's (Fand Respiratory Therapist (Family be re-educated on policy M01-N, Medication Administ by the CNO. 4. How the corrective action be monitored to ensure deficient practice will not recur. Who be responsible? After re-education of	res not RNs) RTs) ration will cient will		

l ·		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCT			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 152016		DING	00	06/27/2	
102010		B. WING		DDDEGG CUTY CTATE TIN CODE	00/21/2	011	
NAME OF PROVIDER OR SUPPLIER					DADWAY 7TH FL E		
SELECT	SPECIALTY HOSP	ITAL-FORT WAYNE			VAYNE, IN46802		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	RNs and RTs are complete, t	ما ما	DATE
	 4. Review of the MAR dated 4-03-11 for patient #26 indicated 3 medications (Famotidine, Gabapentin, Hydralazine) ordered and not designated as given with a slash (/) through the time. 5. Review of the MAR dated 4-04-11 for patient #26 indicated 2 medications (Alprazolam, Hydralazine) ordered and not designated as given with a slash (/) through the time. 				DQM and/or CNO will monitor random MARs per week x 30 days and randomly thereaften eeded, for adherence to pomote to substitution time and initialing and the monthly QAPI committee meetings and reported quartet to OIC/MEC/GB for additional improvement actions as needed. DQM or CNO	or 25 or as dicy in erly	
					Date of Compliance: 10/31/1	11	
S1038	410 IAC 15-1.5-7	(d)(3)(4)(5)(6)					
	(d) Written policies and procedures shall be developed and implemented that include the following:						
		ind biologicals not					
	(4) Allow for adequence monitoring proced						
	(5) Minimize medical document, monitor report adverse drumedication errors.	r, evaluate, and ig reactions and					
		maintenance of information materials. Internation materials.	S10	038	Response to tag S1038 1.Corrective action for the		10/31/2011

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		PITAL-FORT WAYNE		<u> </u>	VAYNE, IN46802		
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TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		cility failed to identify			patients affected by to deficient practice.	ne_	
		lication error for 1 of 7			· The patient affected to	nv	
	patients (pt #21)	which resulted in 6			this practice received the	, y	
	missed doses be	fore the medication was			medication.		
	given to the patie	ent.			2.How other patients with the	<u>e_</u>	
					potential to be affected by th		
	Findings:				deficient practice will be ider	tified_	
	i manigs.				and corrective action taken.		
	1 0 12 24 20	10			 Current patients have been reviewed to determine 	;	
		10, a pharmacy automatic			current orders are being		
	1 *	ument indicated Nystatin			followed. There were no		
	100,000 unit/ml	suspension 5 ml. by			deficiencies found with curre	nt	
	mouth twice daily (stop date 12-25-10 at				patients.		
	21:00 hours) wa	s reordered by the			Measures put into place o	<u>r_</u>	
	physician for par	tient #21.			system changes initiated to		
					ensure deficient practice doe	es not	
	2 On 12-26-10	until 12-29-10, the			recur. Clinical Staff will be		
		ninistration Records			re-educated by the DQM and	d/or	
					CNO to Policy R03A Inciden		
	1 '	documentation of			Reporting and policy M03-P		
	Nystatin adminis	stration for patient #21.			Medication Error Policy.		
					4. How the corrective action		
		physician progress notes			be monitored to ensure defic		
	indicated oral th	rush and Nystatin			practice will not recur. Who	<u>WIII</u>	
	100,000 unit/ml	suspension 5 ml by			<u>be responsible?</u> The DQM will review	5	
	mouth twice dail	ly was ordered again for			random charts weekly.	3	
	patient #21.				Reviewing orders against M	٩R	
					for a 7 day period on each page		
	4 On 6-27-11 a	t 1200, staff #A1			to assure that		
					Transcription/Omission error	s did	
		ne pharmacy had failed to			not occur.	rrore	
	follow the physic	cian order of 12-24-10 to			 DQM will report any e to the CNO for follow up and 		
	reorder Nystatin on 12-25-10 for patient				record in the Incident Report		
	#21.	•			System.		
		11145			· Audit results will be		
	5. On 6-28-11 a	t 1145, staff #A4			reviewed in the monthly QAF		
					committee meetings and rep	orted	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-FORT WAYNE			STREET A	ADDRESS, CITY, STATE, ZIP CODE ROADWAY 7TH FL E WAYNE, IN46802	
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TAG	confirmed that an Nystatin medicat	n incident report of the ion error for patient #21 inpleted by staff at the	TAG	quarterly to OIC/MEC/GB f additional improvement act as needed. 5. Responsible: DQM & CNO Date of Compliance: 10/31	or tions